



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

OLAYINKA OGUNRO, MD  
7989 W. VIRGINIA DR #105  
DALLAS TX 75237

#### **Respondent Name**

WAL MART ASSOCIATES INC

#### **Carrier's Austin Representative Box**

Box Number: 53

#### **MFDR Tracking Number**

M4-12-2438-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** A position summary was not submitted with the request for medical fee dispute resolution.

**Amount in Dispute:** \$475.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The denial was based upon medical necessity and would be subject to an Independent Review Organization. Per Rule 133.305(10): 'Retrospective medical necessity dispute—A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this subchapter.' These services are not subject to medical dispute resolution of fee disputes."

**Response Submitted by:** Hoffman Kelley, 5316 Hwy. 290 West, Ste. 360, Austin, TX 78735

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2012	CPT Codes 99215 and 20552	\$450.00	\$0.00
January 31, 2012	CPT Code 99080-73	\$25.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. This request for medical fee dispute resolution was received by the Division on March 23, 2012.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated February 24, 2012
  - W9 – Unnecessary medical treatment based on peer review.
  - 5077 – Based on a peer review, payment denied because treatment(s)/service(s) is medically unreasonable/unnecessary.

## **Issues**

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

## **Findings**

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that the services rendered using CPT Code 99215 and 20552 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.
3. The requestor also billed CPT Code 99080-73, Work Status Report that was also denied as unnecessary medical treatment based on peer review. In accordance with 28 Texas Administrative Code §129.5(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier **shall** reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided.
4. The requestor did not provide a copy of the Work Status report and has failed to support that the DWC-73, Work Status Report, was submitted as billed. As a result, no amount is ordered.
5. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

## **Conclusion**

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### Authorized Signature

_____	_____	April 25, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**